



110TH CONGRESS
2D SESSION

S. 2662

To respond to a Medicare funding warning.

IN THE SENATE OF THE UNITED STATES

FEBRUARY 25, 2008

Mr. BAUCUS (for himself and Mr. GREGG) (by request) introduced the following bill; which was referred to the Committee on Finance

A BILL

To respond to a Medicare funding warning.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE; REFERENCES; PURPOSE OF LEG-**
4 **ISLATION.**

5 (a) **SHORT TITLE.**—This Act may be cited as the
6 “Medicare Funding Warning Response Act of 2008”.

7 (b) **REFERENCES.**—In this Act:

8 (1) Except where otherwise specifically pro-
9 vided, references in this Act shall be considered to
10 be made to the Social Security Act, or to a section
11 or other provision thereof.

1 (2) The term “Secretary” shall be deemed a
2 reference to the Secretary of Health and Human
3 Services.

4 (3) The terms “Medicare” and “Medicare pro-
5 gram” mean the program under title XVIII of the
6 Social Security Act (42 U.S.C. 1395 et seq.).

7 (4) The Medicare Prescription Drug, Improve-
8 ment, and Modernization Act of 2003 (Public Law
9 108–173) shall be referred to as the “MMA”.

10 (5) The term “excess general revenue medicare
11 funding” has the meaning given such term by sec-
12 tion 801(c) of the MMA.

13 (6) The term “Trustees Report” means the an-
14 nual report submitted under subsection (b)(2) of
15 sections 1817 and 1841 of the Social Security Act
16 (42 U.S.C. 1395i(b)(2) and 1395t(b)(2), respec-
17 tively).

18 (c) PURPOSE.—It is the purpose of this Act to re-
19 spond to the medicare funding warning currently in effect
20 under section 801(a)(2) of the MMA.

1 **TITLE I—INTRODUCING PRIN-**
2 **CIPLES OF VALUE-BASED**
3 **HEALTH CARE INTO THE**
4 **MEDICARE PROGRAM**

5 **SEC. 101. INTRODUCING PRINCIPLES OF VALUE-BASED**
6 **HEALTH CARE INTO THE MEDICARE PRO-**
7 **GRAM.**

8 (a) **ELECTRONIC HEALTH RECORDS.**—The Secretary
9 shall develop and implement a system for encouraging na-
10 tionwide adoption and use of interoperable electronic
11 health records and to make available personal health
12 records for Medicare beneficiaries.

13 (b) **PRICING TRANSPARENCY.**—The Secretary shall
14 make publicly available information on prices and pay-
15 ments under the Medicare program for treatments (includ-
16 ing episodes of care), items, and services to assist Medi-
17 care beneficiaries in making choices among providers,
18 plans, and treatment options.

19 (c) **QUALITY TRANSPARENCY.**—The Secretary shall
20 make publicly available information on the quality of care
21 provided to Medicare beneficiaries to assist them in mak-
22 ing choices among providers, plans, and treatments. To
23 ensure the continued development and evolution of quality
24 measures, the Secretary shall develop and implement a
25 plan for ensuring that, by the year 2013, quality measures

1 are available and reported with respect to at least 50 per-
2 cent of the care provided under the Medicare program (de-
3 termined according to the amount of payment made under
4 such program for items and services with respect to which
5 such measures are available). The Secretary shall report
6 to the Committees on Ways and Means and Energy and
7 Commerce in the House of Representatives and the Com-
8 mittee on Finance in the Senate annually on the progress
9 of the goal specified in the preceding sentence.

10 (d) INCENTIVES FOR VALUE.—

11 (1) INCENTIVES FOR PROVIDERS AND SUP-
12 PLIERS.—

13 (A) IN GENERAL.—The Secretary shall de-
14 sign and implement a system for use in the
15 Medicare program under which a portion of the
16 payments that would otherwise be made under
17 such program to some or all classes of individ-
18 uals and entities furnishing items or services to
19 beneficiaries of such program would be based
20 on the quality and efficiency of their perform-
21 ance.

22 (B) IMPLEMENTATION.—The Secretary
23 shall first implement such system in settings
24 where measures are well-accepted and already
25 collected, including hospitals, physicians' of-

1 fices, home health agencies, skilled nursing fa-
2 cilities, and renal dialysis facilities. The initial
3 focus of such efforts shall be on quality, but the
4 Secretary shall add measures of efficiency as
5 they are identified. The system shall also in-
6 clude incentives for reducing unwarranted geo-
7 graphic variations in quality and efficiency.

8 (C) SECRETARY'S AUTHORITY.—The Sec-
9 retary may implement the system described in
10 this paragraph without regard to any provision
11 of title XVIII of the Social Security Act that
12 would, in the absence of subparagraphs (A) and
13 (B), apply with respect to payment to an indi-
14 vidual or entity furnishing items or services for
15 which payment may be made under the Medi-
16 care program.

17 (2) BENEFICIARY INCENTIVES.—

18 (A) IN GENERAL.—The Secretary shall im-
19 plement incentives for Medicare beneficiaries to
20 use more efficient providers and preventive
21 services known to reduce costs.

22 (B) ACCESS TO HEALTH SAVINGS AC-
23 COUNTS.—The Secretary shall assure a transi-
24 tion into the Medicare program for individuals
25 who are not yet enrolled in such program who

1 own health savings accounts, and shall provide
2 for the availability of high deductible health
3 plan options in the Medicare program.

4 (e) BROADLY TRANSFORMING THE PRIVATE HEALTH
5 CARE MARKETPLACE.—The Secretary shall use and re-
6 lease Medicare data for quality improvement, performance
7 measurement, public reporting, and treatment-related pur-
8 poses. In implementing the preceding sentence, the Sec-
9 retary shall apply risk adjustment techniques where ap-
10 propriate and shall determine the circumstances under
11 which it is appropriate to release such data.

12 (f) PROTECTING INDIVIDUALLY IDENTIFIABLE
13 HEALTH INFORMATION.—In implementing this title, the
14 Secretary shall ensure that individually identifiable bene-
15 ficiary health information is protected (in accordance with
16 the regulations adopted under section 264(c) of the Health
17 Insurance Portability and Accountability Act of 1996 and
18 such other laws and regulations as may apply).

19 (g) REGULATIONS.—The Secretary may implement a
20 system described in this section by regulation, but only
21 if such regulation is issued after public notice and an op-
22 portunity for public comment.

23 (h) DEFINITIONS.—As used in this section:

24 (1) The term “efficiency” means the delivery of
25 health care in a manner that reduces the costs of

1 providing care for Medicare beneficiaries while main-
2 taining or improving the quality of such care.

3 (2) The term “information on quality of care”
4 means such measures of—

5 (A) the use of clinical processes and struc-
6 tures known to improve care;

7 (B) health outcomes; and

8 (C) patient perceptions of their care,
9 as the Secretary may select with preference given to
10 those measures that have been recognized through a
11 consensus-based process.

12 (i) SAVINGS REQUIREMENT.—

13 (1) IN GENERAL.—The Secretary may imple-
14 ment the provisions of subsections (a) through (e) of
15 section 101 and section 102 for a year only to the
16 extent that the Secretary determines (and the Chief
17 Actuary of the Centers for Medicare & Medicaid
18 Services certifies) that—

19 (A) the total amount of payment made
20 under title XVIII of the Social Security Act
21 over the five and ten year periods that begin
22 with January 1 of such year as a result of the
23 implementation of such subsections (a) through
24 (e) and section 102 is less than the amount

1 that would have been made over such periods if
2 such implementation had not occurred; and

3 (B) the total amount of payment made
4 under each of titles XIX and XXI of such Act
5 over such periods as a result of such implemen-
6 tation is no greater than the amount that would
7 have been made under each such title over such
8 periods if such implementation had not oc-
9 curred.

10 (2) AVAILABILITY OF APPROPRIATIONS.—The
11 Secretary shall carry out the provisions of this sec-
12 tion subject to the availability of appropriations and
13 to the extent permitted consistent with paragraph
14 (1).

15 **SEC. 102. RELEASE OF PHYSICIAN PERFORMANCE MEAS-**
16 **UREMENTS.**

17 Section 1848(k) (42 U.S.C. 1395w-4(k)) is amended
18 by adding at the end the following new paragraph:

19 “(9) RELEASE OF QUALITY MEASUREMENTS.—

20 “(A) IN GENERAL.—Notwithstanding sec-
21 tion 552a of title 5, United States Code, the
22 Secretary may—

23 “(i) release to the public physician-
24 specific measurements of the quality or ef-
25 ficiency of physician performance against a

standard (reflecting measurements that have been recognized through a consensus-based process) that has been endorsed by the Secretary; and

“(ii) release, to an entity that will generate or calculate such measurements, data that the entity may use to perform such task.

“(B) ENDORSEMENT OF STANDARDS.—

The Secretary may make an endorsement under subparagraph (A) by publication of a notice in the Federal Register.”.

TITLE II—REDUCING THE EXCESSIVE BURDEN THE LIABILITY SYSTEM PLACES ON THE HEALTH CARE DELIVERY SYSTEM

SEC. 201. SHORT TITLE.

This title may be cited as the “Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2008”.

SEC. 202. FINDINGS AND PURPOSE.

(a) FINDINGS.—

(1) EFFECT ON HEALTH CARE ACCESS AND COSTS.—Congress finds that our current civil justice

1 system is adversely affecting patient access to health
2 care services, better patient care, and cost-efficient
3 health care, in that the health care liability system
4 is a costly and ineffective mechanism for resolving
5 claims of health care liability and compensating in-
6 jured patients, and is a deterrent to the sharing of
7 information among health care professionals which
8 impedes efforts to improve patient safety and quality
9 of care.

10 (2) EFFECT ON INTERSTATE COMMERCE.—

11 Congress finds that the health care and insurance
12 industries are industries affecting interstate com-
13 merce and the health care liability litigation systems
14 existing throughout the United States are activities
15 that affect interstate commerce by contributing to
16 the high costs of health care and premiums for
17 health care liability insurance purchased by health
18 care system providers.

19 (3) EFFECT ON FEDERAL SPENDING.—Con-

20 gress finds that the health care liability litigation
21 systems existing throughout the United States have
22 a significant effect on the amount, distribution, and
23 use of Federal funds because of—

1 (A) the large number of individuals who
2 receive health care benefits under programs op-
3 erated or financed by the Federal Government;

4 (B) the large number of individuals who
5 benefit because of the exclusion from Federal
6 taxes of the amounts spent to provide them
7 with health insurance benefits; and

8 (C) the large number of health care pro-
9 viders who provide items or services for which
10 the Federal Government makes payments.

11 (b) PURPOSE.—It is the purpose of this title to imple-
12 ment reasonable, comprehensive, and effective health care
13 liability reforms designed to—

14 (1) improve the availability of health care serv-
15 ices in cases in which health care liability actions
16 have been shown to be a factor in the decreased
17 availability of services;

18 (2) reduce the incidence of “defensive medi-
19 cine” and lower the cost of health care liability in-
20 surance, all of which contribute to the escalation of
21 health care costs;

22 (3) ensure that persons with meritorious health
23 care injury claims receive fair and adequate com-
24 pensation, including reasonable noneconomic dam-
25 ages;

1 (4) improve the fairness and cost-effectiveness
2 of our current health care liability system to resolve
3 disputes over, and provide compensation for, health
4 care liability by reducing uncertainty in the amount
5 of compensation provided to injured individuals; and

6 (5) provide an increased sharing of information
7 in the health care system which will reduce unin-
8 tended injury and improve patient care.

9 **SEC. 203. ENCOURAGING SPEEDY RESOLUTION OF CLAIMS.**

10 The time for the commencement of a health care law-
11 suit shall be 3 years after the date of manifestation of
12 injury or 1 year after the claimant discovers, or through
13 the use of reasonable diligence should have discovered, the
14 injury, whichever occurs first. In no event shall the time
15 for commencement of a health care lawsuit exceed 3 years
16 after the date of manifestation of injury unless tolled for
17 any of the following—

18 (1) upon proof of fraud;

19 (2) intentional concealment; or

20 (3) the presence of a foreign body, which has no
21 therapeutic or diagnostic purpose or effect, in the
22 person of the injured person.

23 Actions by a minor shall be commenced within 3 years
24 from the date of the alleged manifestation of injury except
25 that actions by a minor under the full age of 6 years shall

1 be commenced within 3 years of manifestation of injury
2 or prior to the minor's 8th birthday, whichever provides
3 a longer period. Such time limitation shall be tolled for
4 minors for any period during which a parent or guardian
5 and a health care provider or health care organization
6 have committed fraud or collusion in the failure to bring
7 an action on behalf of the injured minor.

8 **SEC. 204. COMPENSATING PATIENT INJURY.**

9 (a) **UNLIMITED AMOUNT OF DAMAGES FOR ACTUAL**
10 **ECONOMIC LOSSES IN HEALTH CARE LAWSUITS.**—In any
11 health care lawsuit, nothing in this title shall limit a claim-
12 ant's recovery of the full amount of the available economic
13 damages, notwithstanding the limitation in subsection (b).

14 (b) **ADDITIONAL NONECONOMIC DAMAGES.**—In any
15 health care lawsuit, the amount of noneconomic damages,
16 if available, may be as much as \$250,000, regardless of
17 the number of parties against whom the action is brought
18 or the number of separate claims or actions brought with
19 respect to the same injury.

20 (c) **NO DISCOUNT OF AWARD FOR NONECONOMIC**
21 **DAMAGES.**—For purposes of applying the limitation in
22 subsection (b), future noneconomic damages shall not be
23 discounted to present value. The jury shall not be in-
24 formed about the maximum award for noneconomic dam-
25 ages. An award for noneconomic damages in excess of

1 \$250,000 shall be reduced either before the entry of judg-
2 ment, or by amendment of the judgment after entry of
3 judgment, and such reduction shall be made before ac-
4 counting for any other reduction in damages required by
5 law. If separate awards are rendered for past and future
6 noneconomic damages and the combined awards exceed
7 \$250,000, the future noneconomic damages shall be re-
8 duced first.

9 (d) FAIR SHARE RULE.—In any health care lawsuit,
10 each party shall be liable for that party's several share
11 of any damages only and not for the share of any other
12 person. Each party shall be liable only for the amount of
13 damages allocated to such party in direct proportion to
14 such party's percentage of responsibility. Whenever a
15 judgment of liability is rendered as to any party, a sepa-
16 rate judgment shall be rendered against each such party
17 for the amount allocated to such party. For purposes of
18 this section, the trier of fact shall determine the propor-
19 tion of responsibility of each party for the claimant's
20 harm.

21 **SEC. 205. MAXIMIZING PATIENT RECOVERY.**

22 (a) COURT SUPERVISION OF SHARE OF DAMAGES
23 ACTUALLY PAID TO CLAIMANTS.—In any health care law-
24 suit, the court shall supervise the arrangements for pay-
25 ment of damages to protect against conflicts of interest

1 that may have the effect of reducing the amount of dam-
2 ages awarded that are actually paid to claimants. In par-
3 ticular, in any health care lawsuit in which the attorney
4 for a party claims a financial stake in the outcome by vir-
5 tue of a contingent fee, the court shall have the power
6 to restrict the payment of a claimant's damage recovery
7 to such attorney, and to redirect such damages to the
8 claimant based upon the interests of justice and principles
9 of equity. In no event shall the total of all contingent fees
10 for representing all claimants in a health care lawsuit ex-
11 ceed the following limits:

12 (1) 40 percent of the first \$50,000 recovered by
13 the claimant(s).

14 (2) 33 $\frac{1}{3}$ percent of the next \$50,000 recovered
15 by the claimant(s).

16 (3) 25 percent of the next \$500,000 recovered
17 by the claimant(s).

18 (4) 15 percent of any amount by which the re-
19 covery by the claimant(s) is in excess of \$600,000.

20 (b) APPLICABILITY.—The limitations in this section
21 shall apply whether the recovery is by judgment, settle-
22 ment, mediation, arbitration, or any other form of alter-
23 native dispute resolution. In a health care lawsuit involv-
24 ing a minor or incompetent person, a court retains the
25 authority to authorize or approve a fee that is less than

1 the maximum permitted under this section. The require-
2 ment for court supervision in the first two sentences of
3 subsection (a) applies only in civil actions.

4 **SEC. 206. ADDITIONAL HEALTH BENEFITS.**

5 In any health care lawsuit involving injury or wrong-
6 ful death, any party may introduce evidence of collateral
7 source benefits. If a party elects to introduce such evi-
8 dence, any opposing party may introduce evidence of any
9 amount paid or contributed or reasonably likely to be paid
10 or contributed in the future by or on behalf of the oppos-
11 ing party to secure the right to such collateral source bene-
12 fits. No provider of collateral source benefits shall recover
13 any amount against the claimant or receive any lien or
14 credit against the claimant's recovery or be equitably or
15 legally subrogated to the right of the claimant in a health
16 care lawsuit involving injury or wrongful death. This sec-
17 tion shall apply to any health care lawsuit that is settled
18 as well as a health care lawsuit that is resolved by a fact
19 finder. This section shall not apply to section 1862(b) (42
20 U.S.C. 1395y(b)) or section 1902(a)(25) (42 U.S.C.
21 1396a(a)(25)) of the Social Security Act, or to section
22 8131 or section 8132 of title 5, United States Code. This
23 section shall not apply to section 1862(b) (42 U.S.C.
24 1395y(b)) or section 1902(a)(25) (42 U.S.C.
25 1396a(a)(25)) of the Social Security Act, or to section

1 8131 or section 8132 of title 5, United States Code, or
2 to a collateral source provider that is an employee benefit
3 plan under section 3(3) of the Employee Retirement In-
4 come Security Act of 1974 (29 U.S.C. 1002(3)).

5 **SEC. 207. PUNITIVE DAMAGES.**

6 (a) IN GENERAL.—Punitive damages may, if other-
7 wise permitted by applicable State or Federal law, be
8 awarded against any person in a health care lawsuit only
9 if it is proven by clear and convincing evidence that such
10 person acted with malicious intent to injure the claimant,
11 or that such person deliberately failed to avoid unneces-
12 sary injury that such person knew the claimant was sub-
13 stantially certain to suffer. In any health care lawsuit
14 where no judgment for compensatory damages is rendered
15 against such person, no punitive damages may be awarded
16 with respect to the claim in such lawsuit. No demand for
17 punitive damages shall be included in a health care lawsuit
18 as initially filed. A court may allow a claimant to file an
19 amended pleading for punitive damages only upon a mo-
20 tion by the claimant and after a finding by the court, upon
21 review of supporting and opposing affidavits or after a
22 hearing, after weighing the evidence, that the claimant has
23 established by a substantial probability that the claimant
24 will prevail on the claim for punitive damages. At the re-

1 quest of any party in a health care lawsuit, the trier of
2 fact shall consider in a separate proceeding—

3 (1) whether punitive damages are to be award-
4 ed and the amount of such award; and

5 (2) the amount of punitive damages following a
6 determination of punitive liability.

7 If a separate proceeding is requested, evidence relevant
8 only to the claim for punitive damages, as determined by
9 applicable State law, shall be inadmissible in any pro-
10 ceeding to determine whether compensatory damages are
11 to be awarded.

12 (b) DETERMINING AMOUNT OF PUNITIVE DAM-
13 AGES.—

14 (1) FACTORS CONSIDERED.—In determining
15 the amount of punitive damages, if awarded, in a
16 health care lawsuit, the trier of fact shall consider
17 only the following—

18 (A) the severity of the harm caused by the
19 conduct of such party;

20 (B) the duration of the conduct or any
21 concealment of it by such party;

22 (C) the profitability of the conduct to such
23 party;

24 (D) the number of products sold or med-
25 ical procedures rendered for compensation, as

1 the case may be, by such party, of the kind
2 causing the harm complained of by the claim-
3 ant;

4 (E) any criminal penalties imposed on such
5 party, as a result of the conduct complained of
6 by the claimant; and

7 (F) the amount of any civil fines assessed
8 against such party as a result of the conduct
9 complained of by the claimant.

10 (2) MAXIMUM AWARD.—The amount of punitive
11 damages, if awarded, in a health care lawsuit may
12 be as much as \$250,000 or as much as two times
13 the amount of economic damages awarded, which-
14 ever is greater. The jury shall not be informed of
15 this limitation.

16 (c) NO PUNITIVE DAMAGES FOR PRODUCTS THAT
17 COMPLY WITH FDA STANDARDS.—

18 (1) IN GENERAL.—

19 (A) No punitive damages may be awarded
20 against the manufacturer or distributor of a
21 medical product, or a supplier of any compo-
22 nent or raw material of such medical product,
23 based on a claim that such product caused the
24 claimant's harm where—

1 (i)(I) such medical product was sub-
2 ject to premarket approval, clearance, or li-
3 censure by the Food and Drug Administra-
4 tion with respect to the safety of the for-
5 mulation or performance of the aspect of
6 such medical product which caused the
7 claimant's harm or the adequacy of the
8 packaging or labeling of such medical
9 product; and

10 (II) such medical product was so ap-
11 proved, cleared, or licensed; or

12 (ii) such medical product is generally
13 recognized among qualified experts as safe
14 and effective pursuant to conditions estab-
15 lished by the Food and Drug Administra-
16 tion and applicable Food and Drug Admin-
17 istration regulations, including without
18 limitation those related to packaging and
19 labeling, unless the Food and Drug Admin-
20 istration has determined that such medical
21 product was not manufactured or distrib-
22 uted in substantial compliance with appli-
23 cable Food and Drug Administration stat-
24 utes and regulations.

1 (B) RULE OF CONSTRUCTION.—Subpara-
2 graph (A) may not be construed as establishing
3 the obligation of the Food and Drug Adminis-
4 tration to demonstrate affirmatively that a
5 manufacturer, distributor, or supplier referred
6 to in such subparagraph meets any of the con-
7 ditions described in such subparagraph.

8 (2) LIABILITY OF HEALTH CARE PROVIDERS.—
9 A health care provider who prescribes, or who dis-
10 penses pursuant to a prescription, a medical product
11 approved, licensed, or cleared by the Food and Drug
12 Administration shall not be named as a party to a
13 product liability lawsuit involving such product and
14 shall not be liable to a claimant in a class action
15 lawsuit against the manufacturer, distributor, or
16 seller of such product. Nothing in this paragraph
17 prevents a court from consolidating cases involving
18 health care providers and cases involving products li-
19 ability claims against the manufacturer, distributor,
20 or product seller of such medical product.

21 (3) PACKAGING.—In a health care lawsuit for
22 harm which is alleged to relate to the adequacy of
23 the packaging or labeling of a drug which is required
24 to have tamper-resistant packaging under regula-
25 tions of the Secretary of Health and Human Serv-

1 ices (including labeling regulations related to such
2 packaging), the manufacturer or product seller of
3 the drug shall not be held liable for punitive dam-
4 ages unless such packaging or labeling is found by
5 the trier of fact by clear and convincing evidence to
6 be substantially out of compliance with such regula-
7 tions.

8 (4) EXCEPTION.—Paragraph (1) shall not
9 apply in any health care lawsuit in which—

10 (A) a person, before or after premarket ap-
11 proval, clearance, or licensure of such medical
12 product, knowingly misrepresented to or with-
13 held from the Food and Drug Administration
14 information that is required to be submitted
15 under the Federal Food, Drug, and Cosmetic
16 Act (21 U.S.C. 301 et seq.) or section 351 of
17 the Public Health Service Act (42 U.S.C. 262)
18 that is material and is causally related to the
19 harm which the claimant allegedly suffered; or

20 (B) a person made an illegal payment to
21 an official of the Food and Drug Administra-
22 tion for the purpose of either securing or main-
23 taining approval, clearance, or licensure of such
24 medical product.

1 **SEC. 208. AUTHORIZATION OF PAYMENT OF FUTURE DAM-**
2 **AGES TO CLAIMANTS IN HEALTH CARE LAW-**
3 **SUITS.**

4 (a) **IN GENERAL.**—In any health care lawsuit, if an
5 award of future damages, without reduction to present
6 value, equaling or exceeding \$50,000 is made against a
7 party with sufficient insurance or other assets to fund a
8 periodic payment of such a judgment, the court shall, at
9 the request of any party, enter a judgment ordering that
10 the future damages be paid by periodic payments. In any
11 health care lawsuit, the court may be guided by the Uni-
12 form Periodic Payment of Judgments Act promulgated by
13 the National Conference of Commissioners on Uniform
14 State Laws.

15 (b) **APPLICABILITY.**—This section applies to all ac-
16 tions which have not been first set for trial or retrial be-
17 fore the effective date of this Act.

18 **SEC. 209. DEFINITIONS.**

19 In this title:

20 (1) **ALTERNATIVE DISPUTE RESOLUTION SYS-**
21 **TEM; ADR.**—The term “alternative dispute resolution
22 system” or “ADR” means a system that provides
23 for the resolution of health care lawsuits in a man-
24 ner other than through a civil action brought in a
25 State or Federal court.

1 (2) CLAIMANT.—The term “claimant” means
2 any person who brings a health care lawsuit, includ-
3 ing a person who asserts or claims a right to legal
4 or equitable contribution, indemnity or subrogation,
5 arising out of a health care liability claim or action,
6 and any person on whose behalf such a claim is as-
7 serted or such an action is brought, whether de-
8 ceased, incompetent, or a minor.

9 (3) COLLATERAL SOURCE BENEFITS.—The
10 term “collateral source benefits” means any amount
11 paid or reasonably likely to be paid in the future to
12 or on behalf of the claimant, or any service, product
13 or other benefit provided or reasonably likely to be
14 provided in the future to or on behalf of the claim-
15 ant, as a result of the injury or wrongful death, pur-
16 suant to—

17 (A) any State or Federal health, sickness,
18 income-disability, accident, or workers’ com-
19 pensation law (except the Federal Employees’
20 Compensation Act (5 U.S.C. 8101 et seq.));

21 (B) any health, sickness, income-disability,
22 or accident insurance that provides health bene-
23 fits or income-disability coverage;

24 (C) any contract or agreement of any
25 group, organization, partnership, or corporation

1 to provide, pay for, or reimburse the cost of
2 medical, hospital, dental, or income disability
3 benefits; and

4 (D) any other publicly or privately funded
5 program.

6 (4) COMPENSATORY DAMAGES.—The term
7 “compensatory damages” means objectively
8 verifiable monetary losses incurred as a result of the
9 provision of, use of, or payment for (or failure to
10 provide, use, or pay for) health care services or med-
11 ical products, such as past and future medical ex-
12 penses, loss of past and future earnings, cost of ob-
13 taining domestic services, loss of employment, and
14 loss of business or employment opportunities, dam-
15 ages for physical and emotional pain, suffering, in-
16 convenience, physical impairment, mental anguish,
17 disfigurement, loss of enjoyment of life, loss of soci-
18 ety and companionship, loss of consortium (other
19 than loss of domestic service), hedonic damages, in-
20 jury to reputation, and all other nonpecuniary losses
21 of any kind or nature. The term “compensatory
22 damages” includes economic damages and non-
23 economic damages, as such terms are defined in this
24 section.

1 (5) CONTINGENT FEE.—The term “contingent
2 fee” includes all compensation to any person or per-
3 sons which is payable only if a recovery is effected
4 on behalf of one or more claimants.

5 (6) ECONOMIC DAMAGES.—The term “economic
6 damages” means objectively verifiable monetary
7 losses incurred as a result of the provision of, use
8 of, or payment for (or failure to provide, use, or pay
9 for) health care services or medical products, such as
10 past and future medical expenses, loss of past and
11 future earnings, cost of obtaining domestic services,
12 loss of employment, and loss of business or employ-
13 ment opportunities.

14 (7) HEALTH CARE LAWSUIT.—The term
15 “health care lawsuit” means any health care liability
16 claim concerning the provision of health care goods
17 or services or any medical product affecting inter-
18 state commerce, or any health care liability action
19 concerning the provision of health care goods or
20 services or any medical product affecting interstate
21 commerce, brought in a State or Federal court or
22 pursuant to an alternative dispute resolution system,
23 against a health care provider, a health care organi-
24 zation, or the manufacturer, distributor, supplier,
25 marketer, promoter, or seller of a medical product,

1 regardless of the theory of liability on which the
2 claim is based, or the number of claimants, plain-
3 tiffs, defendants, or other parties, or the number of
4 claims or causes of action, in which the claimant al-
5 leges a health care liability claim. Such term does
6 not include a claim brought by the United States
7 Government or a relator under the False Claims Act
8 (31 U.S.C. 3729 et seq.) or a claim or action which
9 is based on criminal liability; which seeks civil fines
10 or penalties paid to Federal, State, or local govern-
11 ment; or which is grounded in antitrust.

12 (8) HEALTH CARE LIABILITY ACTION.—The
13 term “health care liability action” means a civil ac-
14 tion brought in a State or Federal Court or pursu-
15 ant to an alternative dispute resolution system,
16 against a health care provider, a health care organi-
17 zation, or the manufacturer, distributor, supplier,
18 marketer, promoter, or seller of a medical product,
19 regardless of the theory of liability on which the
20 claim is based, or the number of plaintiffs, defend-
21 ants, or other parties, or the number of causes of ac-
22 tion, in which the claimant alleges a health care li-
23 ability claim.

24 (9) HEALTH CARE LIABILITY CLAIM.—The
25 term “health care liability claim” means a demand

1 by any person, whether or not pursuant to ADR,
2 against a health care provider, health care organiza-
3 tion, or the manufacturer, distributor, supplier, mar-
4 keter, promoter, or seller of a medical product, in-
5 cluding, but not limited to, third-party claims, cross-
6 claims, counter-claims, or contribution claims, which
7 are based upon the provision of, use of, or payment
8 for (or the failure to provide, use, or pay for) health
9 care services or medical products, regardless of the
10 theory of liability on which the claim is based, or the
11 number of plaintiffs, defendants, or other parties, or
12 the number of causes of action.

13 (10) HEALTH CARE ORGANIZATION.—The term
14 “health care organization” means any person or en-
15 tity which is obligated to provide or pay for health
16 benefits under any health plan, including any person
17 or entity acting under a contract or arrangement
18 with a health care organization to provide or admin-
19 ister any health benefit.

20 (11) HEALTH CARE PROVIDER.—The term
21 “health care provider” means any person or entity
22 required by State or Federal laws or regulations to
23 be licensed, registered, or certified to provide health
24 care services, and being either so licensed, reg-

1 istered, or certified, or exempted from such require-
2 ment by other statute or regulation.

3 (12) HEALTH CARE GOODS OR SERVICES.—The
4 term “health care goods or services” means any
5 goods or services provided by a health care organiza-
6 tion, provider, or by any individual working under
7 the supervision of a health care provider, that relates
8 to the diagnosis, prevention, or treatment of any
9 human disease or impairment, or the assessment or
10 care of the health of human beings.

11 (13) MALICIOUS INTENT TO INJURE.—The
12 term “malicious intent to injure” means inten-
13 tionally causing or attempting to cause physical in-
14 jury other than providing health care goods or serv-
15 ices.

16 (14) MEDICAL PRODUCT.—The term “medical
17 product” means a drug, device, or biological product
18 intended for humans, and the terms “drug”, “de-
19 vice”, and “biological product” have the meanings
20 given such terms in sections 201(g)(1) and 201(h)
21 of the Federal Food, Drug and Cosmetic Act (21
22 U.S.C. 321) and section 351(a) of the Public Health
23 Service Act (42 U.S.C. 262(a)), respectively, includ-
24 ing any component or raw material used therein, but
25 excluding health care services.

1 (15) NONECONOMIC DAMAGES.—The term
2 “noneconomic damages” means damages for phys-
3 ical and emotional pain, suffering, inconvenience,
4 physical impairment, mental anguish, disfigurement,
5 loss of enjoyment of life, loss of society and compan-
6 ionship, loss of consortium (other than loss of do-
7 mestic service), hedonic damages, injury to reputa-
8 tion, and all other nonpecuniary losses of any kind
9 or nature.

10 (16) PUNITIVE DAMAGES.—The term “punitive
11 damages” means damages awarded, for the purpose
12 of punishment or deterrence, and not solely for com-
13 pensatory purposes, against a health care provider,
14 health care organization, or a manufacturer, dis-
15 tributor, or supplier of a medical product. Punitive
16 damages are neither economic nor noneconomic
17 damages.

18 (17) RECOVERY.—The term “recovery” means
19 the net sum recovered after deducting any disburse-
20 ments or costs incurred in connection with prosecu-
21 tion or settlement of the claim, including all costs
22 paid or advanced by any person. Costs of health care
23 incurred by the plaintiff and the attorneys’ office
24 overhead costs or charges for legal services are not
25 deductible disbursements or costs for such purpose.

(18) STATE.—The term “State” means each of the several States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, the Trust Territory of the Pacific Islands, and any other territory or possession of the United States, or any political subdivision thereof.

SEC. 210. EFFECT ON OTHER LAWS.

(a) VACCINE INJURY.—

(1) To the extent that title XXI of the Public Health Service Act establishes a Federal rule of law applicable to a civil action brought for a vaccine-related injury or death—

(A) this title does not affect the application of the rule of law to such an action; and

(B) any rule of law prescribed by this title in conflict with a rule of law of such title XXI shall not apply to such action.

(2) If there is an aspect of a civil action brought for a vaccine-related injury or death to which a Federal rule of law under title XXI of the Public Health Service Act does not apply, then this title or otherwise applicable law (as determined under this title) will apply to such aspect of such action.

1 (b) OTHER FEDERAL LAW.—Except as provided in
2 this section, nothing in this title shall be deemed to affect
3 any defense available to a defendant in a health care law-
4 suit or action under any other provision of Federal law.

5 **SEC. 211. STATE FLEXIBILITY AND PROTECTION OF**
6 **STATES' RIGHTS.**

7 (a) HEALTH CARE LAWSUITS.—The provisions gov-
8 erning health care lawsuits set forth in this title preempt,
9 subject to subsections (b) and (c), State law to the extent
10 that State law prevents the application of any provisions
11 of law established by or under this title. The provisions
12 governing health care lawsuits set forth in this title super-
13 sede chapter 171 of title 28, United States Code, to the
14 extent that such chapter—

15 (1) provides or allows for a greater amount of
16 damages or contingent fees, or a longer period in
17 which a health care lawsuit may be commenced,
18 than provided in this title;

19 (2) precludes or reduces the applicability or
20 scope of periodic payment of future damages as pro-
21 vided in this title; or

22 (3) through application of State law, conflicts
23 with provisions of this title concerning joint liability,
24 collateral source benefits, subrogation, or liens.

1 (b) PROTECTION OF STATES' RIGHTS AND OTHER
2 LAWS.—

3 (1) Any issue that is not governed by any provi-
4 sion of law established by or under this title (includ-
5 ing State standards of negligence) shall be governed
6 by otherwise applicable State or Federal law.

7 (2) This title shall not preempt or supersede
8 any State or Federal law that imposes greater proce-
9 dural or substantive protections for health care pro-
10 viders and health care organizations from liability,
11 loss, or damages than those provided by this title or
12 create a cause of action.

13 (c) STATE FLEXIBILITY.—No provision of this title
14 shall be construed to preempt—

15 (1) any State law (whether effective before, on,
16 or after the date of the enactment of this title) that
17 specifies a particular monetary amount of compen-
18 satory or punitive damages (or the total amount of
19 damages) that may be awarded in a health care law-
20 suit, regardless of whether such monetary amount is
21 greater or lesser than is provided for under this title,
22 notwithstanding section 204(a); or

23 (2) any defense available to a party in a health
24 care lawsuit under any other provision of State or
25 Federal law.

1 SEC. 212. APPLICABILITY; EFFECTIVE DATE.

2 This title shall apply to any health care lawsuit
3 brought in a Federal or State court, or subject to an alter-
4 native dispute resolution system, that is initiated on or
5 after the date of the enactment of this title, except that
6 any health care lawsuit arising from an injury occurring
7 prior to the date of the enactment of this title shall be
8 governed by the applicable statute of limitations provisions
9 in effect at the time the injury occurred.

10 TITLE III—INCREASING HIGH-IN-
11 COME BENEFICIARY AWARE-
12 NESS AND RESPONSIBILITY
13 FOR HEALTH CARE COSTS

14 SEC. 301. INCOME-RELATED REDUCTION IN PART D PRE-
15 MIUM SUBSIDY.

16 (a) INCOME-RELATED REDUCTION IN PART D PRE-
17 MIUM SUBSIDY.—

18 (1) IN GENERAL.—Section 1860D–13(a) (42
19 U.S.C. 1395w–113(a)) is amended by adding at the
20 end the following new paragraph:

21 “(7) REDUCTION IN PREMIUM SUBSIDY BASED
22 ON INCOME.—

23 “(A) IN GENERAL.—In the case of an indi-
24 vidual whose modified adjusted gross income
25 exceeds the threshold amount applicable under
26 subparagraph (B) for the calendar year, the

1 monthly amount of the premium subsidy appli-
2 cable to the premium under this section for a
3 month after December 2008 shall be reduced
4 (and the monthly beneficiary premium shall be
5 increased) by the monthly adjustment amount
6 specified in subparagraph (C).

7 “(B) THRESHOLD AMOUNT.—For purposes
8 of this paragraph, the threshold amount is—

9 “(i) except as provided in clause (ii),
10 \$82,000; and

11 “(ii) in the case of a joint return,
12 twice the amount applicable under clause
13 (i) for the calendar year.

14 “(C) MONTHLY ADJUSTMENT AMOUNT.—

15 “(i) IN GENERAL.—The monthly ad-
16 justment amount specified in this subpara-
17 graph for an individual for a month in a
18 year is equal to the product of—

19 “(I) the quotient obtained by di-
20 viding—

21 “(aa) the applicable percent-
22 age specified in the table in
23 clause (ii) for the individual for
24 the calendar year reduced by
25 25.5 percent; by

1 “(bb) 25.5 percent; and
 2 “(II) the base beneficiary pre-
 3 mium (as computed under paragraph
 4 (2)).
 5 “(ii) APPLICABLE PERCENTAGE.—
 6 “(I) IN GENERAL.—

“If the modified adjusted gross in- come is:	The applicable percentage is:
More than \$82,000 but not more than \$102,000	35 percent
More than \$102,000 but not more than \$153,000	50 percent
More than \$153,000 but not more than \$205,000	65 percent
More than \$205,000	80 percent.

7 “(II) JOINT RETURNS.—In the
 8 case of a joint return, subclause (I)
 9 shall be applied by substituting dollar
 10 amounts which are twice the dollar
 11 amounts otherwise applicable under
 12 subclause (I) for the calendar year.

13 “(III) MARRIED INDIVIDUALS
 14 FILING SEPARATE RETURNS.—In the
 15 case of an individual who—

16 “(aa) is married as of the
 17 close of the taxable year (within
 18 the meaning of section 7703 of
 19 the Internal Revenue Code of
 20 1986) but does not file a joint re-
 21 turn for such year, and

“(bb) does not live apart from such individual’s spouse at all times during the taxable year, subclause (I) shall be applied by reducing each of the dollar amounts otherwise applicable under such subclause for the calendar year by the threshold amount for such year applicable to an unmarried individual.

“(D) DETERMINATION BY COMMISSIONER OF SOCIAL SECURITY.—The Commissioner of Social Security shall have the authority to make initial and reconsideration determinations necessary to carry out the income-related reduction in premium subsidy under this paragraph.

“(E) MODIFIED ADJUSTED GROSS INCOME.—For purposes of this paragraph, the term ‘modified adjusted gross income’ has the meaning given such term in subparagraph (A) of section 1839(i)(4), determined for the taxable year applicable under subparagraphs (B) and (C) of such section.

“(F) JOINT RETURN DEFINED.—For purposes of this paragraph, the term ‘joint return’ has the meaning given to such term by section

1 7701(a)(38) of the Internal Revenue Code of
2 1986.

3 “(G) PROCEDURES TO ASSURE CORRECT
4 INCOME-RELATED REDUCTION IN PREMIUM
5 SUBSIDY.—

6 “(i) DISCLOSURE OF BASE BENE-
7 FICIARY PREMIUM.—Not later than Sep-
8 tember 15 of each year beginning with
9 2008, the Secretary shall disclose to the
10 Commissioner of Social Security the
11 amount of the base beneficiary premium
12 (as computed under paragraph (2)) for the
13 purpose of carrying out the income-related
14 reduction in premium subsidy under this
15 paragraph with respect to the following
16 year.

17 “(ii) ADDITIONAL DISCLOSURE.—Not
18 later than October 15 of each year begin-
19 ning with 2008, the Secretary shall dis-
20 close to the Commissioner of Social Secu-
21 rity the following information for the pur-
22 pose of carrying out the income-related re-
23 duction in premium subsidy under this
24 paragraph with respect to the following
25 year:

1 “(I) The monthly adjustment
2 amount specified in subparagraph (C).

3 “(II) Any other information the
4 Commissioner of Social Security de-
5 termines necessary to carry out the
6 income-related reduction in premium
7 subsidy under this paragraph.

8 “(H) RULE OF CONSTRUCTION.—The for-
9 mula used to determine the monthly adjustment
10 amount specified under subparagraph (C) shall
11 only be used for the purpose of determining
12 such monthly adjustment amount under such
13 subparagraph.”.

14 (2) COLLECTION OF MONTHLY ADJUSTMENT
15 AMOUNT.—Section 1860D–13(c) (42 U.S.C. 1395w–
16 113(c)) is amended—

17 (A) in paragraph (1), by striking “(2) and
18 (3)” and inserting “(2), (3), and (4)”; and

19 (B) by adding at the end the following new
20 paragraph:

21 “(4) COLLECTION OF MONTHLY ADJUSTMENT
22 AMOUNT.—

23 “(A) IN GENERAL.—Notwithstanding any
24 provision of this subsection or section
25 1854(d)(2), subject to subparagraph (B), the

1 amount of the income-related reduction in pre-
2 mium subsidy for an individual for a month (as
3 determined under subsection (a)(7)) shall be
4 paid through withholding from benefit pay-
5 ments in the manner provided under section
6 1840.

7 “(B) AGREEMENTS.—In the case where
8 the monthly benefit payments of an individual
9 that are withheld under subparagraph (A) are
10 insufficient to pay the amount described in such
11 subparagraph, the Commissioner of Social Se-
12 curity shall enter into agreements with the Sec-
13 retary, the Director of the Office of Personnel
14 Management, and the Railroad Retirement
15 Board as necessary in order to allow other
16 agencies to collect the amount described in sub-
17 paragraph (A) that was not withheld under
18 such subparagraph.”.

19 (b) CONFORMING AMENDMENTS.—

20 (1) MEDICARE.—Part D of title XVIII (42
21 U.S.C. 1395w-101 et seq.) is amended—

22 (A) in section 1860D-13(a)(1)—

23 (i) by redesignating subparagraph (F)
24 as subparagraph (G);

1 (ii) in subparagraph (G), as redesign-
 2 nated by subparagraph (A), by striking
 3 “(D) and (E)” and inserting “(D), (E),
 4 and (F)”; and

5 (iii) by inserting after subparagraph
 6 (E) the following new subparagraph:

7 “(F) INCREASE BASED ON INCOME.—The
 8 monthly beneficiary premium shall be increased
 9 pursuant to paragraph (7).”; and

10 (B) in section 1860D–15(a)(1)(B), by
 11 striking “paragraph (1)(B)” and inserting
 12 “paragraphs (1)(B) and (1)(F)”.

13 (2) INTERNAL REVENUE CODE.—Section
 14 6103(l)(20) of the Internal Revenue Code of 1986
 15 (relating to disclosure of return information to carry
 16 out Medicare part B premium subsidy adjustment)
 17 is amended—

18 (A) in the heading, by striking “PART B
 19 PREMIUM SUBSIDY ADJUSTMENT” and inserting
 20 “PARTS B AND D PREMIUM SUBSIDY ADJUST-
 21 MENTS”;

22 (B) in subparagraph (A)—

23 (i) in the matter preceding clause (i),
 24 by inserting “or 1860D–13(a)(7)” after
 25 “1839(i)”; and

1 (ii) in clause (vii), by inserting after
2 “subsection (i) of such section” the fol-
3 lowing: “or under section 1860D–13(a)(7)
4 of such Act”; and
5 (C) in subparagraph (B)—

6 (i) by inserting “or such section
7 1860D–13(a)(7)” before the period at the
8 end;

9 (ii) as amended by clause (i), by add-
10 ing at the end the following new sentence:
11 “Such return information may be disclosed
12 to officers and employees of the Depart-
13 ments of Health and Human Services and
14 Justice, to the extent necessary, and solely
15 for their use, in any administrative or judi-
16 cial proceeding ensuing from an adjust-
17 ment to any such premium.”; and

18 (D) by adding at the end the following new
19 subparagraph:

20 “(C) TIMING OF DISCLOSURE.—Return in-
21 formation shall be disclosed to officers, employ-
22 ees, and contractors of the Social Security Ad-
23 ministration under subparagraph (A):

24 “(i) for taxpayers currently entitled to
25 benefits under title II of the Social Secu-

1 rity Act, or as qualified railroad retirement
2 beneficiaries within the meaning of section
3 7(d) of the Railroad Retirement Act of
4 1974. within 4 months preceding the
5 month in which the taxpayer first becomes
6 entitled to benefits under part A or is eligi-
7 ble to enroll in part B or part D of title
8 XVIII of the Social Security Act; and

9 “(ii) for taxpayers not currently re-
10 ceiving benefits under title II of the Social
11 Security Act, or as qualified railroad re-
12 tirement beneficiaries within the meaning
13 of section 7(d) of the Railroad Retirement
14 Act of 1974, or who have participated in
15 Medicare qualified government employment
16 as defined in section 210(p) of the Social
17 Security Act, after the taxpayer applies for
18 a benefit under part A or part B and is eli-
19 gible to enroll in part D of title XVIII of
20 the Social Security Act.”.

21 (c) IMPLEMENTATION.—Notwithstanding any other
22 provision of law, the Secretary, in consultation with the
23 Commissioner of Social Security may implement this sec-

- 1 tion, and the amendments made by this section, by pro-
- 2 gram instruction or otherwise.

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